PLAN OF CARE / COST COMPARISON BUDGET FOR THE AL AND AFC WAIVER

State Form 50149 (9-01) / HCBS 1F/2F
Approved by State Board of Accounts, 2001

Information contained in this record is **CONFIDENTIAL** pursuant to 42 CFR 431(f).

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CENTRAL OFFICE USE ONLY		
	Date	**Initials**
OMPP		
MWU		
Returned		

☐ Initial Plan of Care ☐ Update Plan of Care ☐ Annual Plan of Care
☐ Re-Entry - Previous Termination Date _____

Last name	First name	Middle initial	Area agency number	BDDS number

Address *(number and street, rural route or box number)*	City	State	ZIP code

Medicaid number	Medicaid eligibility date	Date of birth	Social Security number

Level of Care *(please check)* ☐ B00 ☐ B50	Level of Care - current approval date (*month, day, year*)	Level of Care - previous approval date (*month, day, year*)

Diagnosis 1 *(from 450B)*	Diagnosis 2 *(from 450B)*

Start Date Waiver Effective Date		**Medicaid Facility Discharge Date**	

Recommendation **Level of Service Point Total:**

Plan of Care Beginning From To

A. HOME AND COMMUNITY-BASED CARE COSTS (*Calculations are based on 30 days*)

1. Plan of Care Information: Monthly Authorizations:

Case Management	CMGT	(0.25 Hour) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____
Assisted Living - Level 1	AL1	(1.00 Day) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____
Assisted Living - Level 2	AL2	(1.00 Day) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____
Assisted Living - Level 3	AL3	(1.00 Day) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____
Assisted Living - Level 4	AL4	(1.00 Day) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____
Assisted Living - Level 5	AL5	(1.00 Day) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____
Adult Foster Care - Level 1	AFC 1	(1.00 Day) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____
Adult Foster Care - Level 2	AFC 2	(1.00 Day) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____
Adult Foster Care - Level 3	AFC 3	(1.00 Day) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____
Adult Foster Care - Level 4	AFC 4	(1.00 Day) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____
Adult Foster Care - Level 5	AFC 5	(1.00 Day) units auth. / mo. _____	X rate $ _____ = M/Cst $ _____

2. Other Medicaid Services

a. Physician . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____
b. Pharmacy . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____
c. Therapy . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____
d. Lab / X-ray . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____
e. Supplies . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____
f. Durable medical Equipment . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____
g. Transportation . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____
h. Other _____ . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____
i. Other _____ . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____
j. Other _____ . . . . . 3 mo. payment history $ _____ ÷ 3 = Estimate mo. cost $ _____

TOTAL A.2 - Other Medicaid Cost $ _____

3. Total of Lines A.1 $ _____ + A.2 $ _____ = $ _____ A.3

Case management agency

Case manager I.D. number *(4 digits)* | Case manager authorization. number *(9 digits)*

4. Minus Recipient Spend-down Amount - $ _____ A.4

5. Total Home and Community Care Costs = $ _____ A.5

Date budget completed *(mo., day, yr.)*

B. DOCUMENTATION OF PAYMENT HISTORY *(indicate sources and dates of information used to determine cost report in Section A.2)*

C. NON-REIMBURSED CAREGIVER(S) *(i.e., family, friends)*

Type	Provider *(specify name and address)*	Telephone Number	Frequency
PRIMARY CAREGIVER	Name Address		

D. DESCRIPTION *(please describe how the Plan of Care provides adequate coverage to ensure the health and welfare of the waiver services recipient. For Update Plan of Care, explain reason for change.)*

E. FREEDOM OF CHOICE

A Medicaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and Community-Based Services Waiver. I have been fully informed of the services available to me in a Nursing Facility institutional setting. I understand the alternatives available and have been given the opportunity to choose between waiver services in a home and community-based setting and institutional care. As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services in a home and community-based setting and institutional care.

1. Choice of Waiver Services

☐ At this time, I have chosen to receive waiver services in a home and community-based setting, rather than services in an institutional setting.

Signature of recipient / guardian	Date signed *(month, day, year)*

2. Choice of Institutional Services

☐ At this time, I have chosen to receive services in an institutional setting, rather than in a home and community-based setting.

Signature of recipient / guardian	Date signed *(month, day, year)*

F. CHOICE OF PROVIDERS

If the recipient chooses to receive waiver services in a home and community-based setting, they have the right to select any approved waiver service provider(s).

☐ I have been informed of my right to choose any certified waiver service provider when selecting waiver service providers.

Signature of recipient / guardian	Date signed *(month, day, year)*

G. EMERGENCY BACKUP PLANS

Describe how medical needs, supervision, behavior issues, etc., will be covered during an emergency.

H. NOTES *(including documentation of unmet needs)*

I. SIGNATURES

Signature of Case Manager	Case Manager I.D. number	Date signed *(month, day, year)*
AAA signature	I.D. number	Date signed *(month, day, year)*
BDDS signature		Date signed *(month, day, year)*

J. STATE AGENCY PLAN OF CARE DETERMINATION

☐ Approved ☐ Disapproved

Signature of Authorized Waiver Program Representative	Date signed *(month, day, year)*